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# The landscape of postgraduate education in palliative care for general practitioners: results of a nationwide survey in Flanders, Belgium

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ABSTRACT

*Objective:* To describe the offer of continuing medical education (CME) in palliative care in Flanders, Belgium and to explore the way providers of CME address the preferences of general practitioners (GP's) towards CME.
*Methods:* Questionnaire-survey among official providers of formal CME.
*Results:* The response rate was 43%, equally distributed over all 5 provinces of Flanders. Data show large content gaps, an under usage of appropriate educational techniques and an absence of evaluation of the impact of CME on clinical practice. Providers of CME explain how they take the preferences of GP's concerning education in palliative care into account.
*Conclusions:* The present offer of CME is insufficient to educate GP's in palliative care. The absence of quality criteria and the lack of coordination between different providers results in an unattractive labyrinth of courses leaving GP's and their patients in the cold.
*Practice implications:* A comprehensive offer of CME sessions should be installed in a coordination between all providers. This could render the use of means (logistics and speakers) more efficient. Further research could look into other ways of acquiring palliative care competences such as evaluating the learning effect of GP's working together with specialized palliative home care teams.


## 1. Introduction

In most European countries the development of palliative care services has increased gradually during the last decades [1]. Home care teams, hospices, support teams in hospitals and specialized palliative care units have been established in most countries. An ageing population with increasing numbers of patients suffering from advanced cancer and severe non-malignant diseases will reinforce the need for palliative care. Delivering high quality palliative care is a difficult, complex and demanding task which should be executed by sufficiently educated and trained professionals [2]. Several countries have installed an undergraduate palliative care curriculum and suggestions are made to consider palliative medicine to be a medical (sub-) specialty [3]. A growing number of doctors acquire an official certification in palliative medicine [4].

A majority of palliative patients prefers to spend their final days in their own homes, expecting their general practitioner (GP) to take care of them [5–7]. GP's consider palliative home care as an essential part of their job responsibilities and are willing to undertake this challenge [8,9]. According to the palliative care philosophy of interdisciplinary teamwork GP's are working together with community nurses, palliative care specialists in hospitals and, in Belgium as in several other countries, with specialized palliative home care teams.

GP's play a key role in health care in Belgium. Patients are stimulated to enlist with a GP and to first contact him with medical problems instead of looking for specialist care directly. As for palliative care this way of promoting primary care is reinforced with financial incentives for the patient (full reimbursement of GP fees) and with support of specialized palliative home care teams which intervene free of charges for the patient. Furthermore specialized palliative care units (where patients are hospitalized) are insufficient to take care of all palliative patients (29 units with a mean of 10 beds per unit for 6 million people) and there are no hospices. A recent survey shows that approximately 90% of the palliative patients want to receive care by their GP (at home or in a nursing home) while only about 50% of the non-sudden deaths occur at home or in a nursing home indicating that GP's might need extra support in their palliative home care delivery [10,11]. Specific palliative care training can be part of that support.

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This training should be offered to all GP's since in Belgium 40% is still working alone. Even for those working in group practices it is necessary to acquire basic palliative care competences since patients can choose their GP, which they do. Moreover a lack of GP involvement in palliative care (often by lack of confidence in their own skills) may lead to high hospitalization rates which is against the preferred place of death by the patient [8,11].

Belgium, as several other European countries [1], does not have a mandatory undergraduate palliative care curriculum for medical students though universities voluntarily make efforts to fill this gap. They present undergraduate palliative care education as a single course without real integration in the medical curriculum. Practical experience during traineeship differs according to workplace environment and tutorship.

As a result GP's highly depend on continuing medical education (CME) to develop their palliative care competences. The importance of this CME cannot be overestimated. It should encompass theoretical knowledge and practical skills besides training in teamwork and communication [12]. In Belgium GP's are licensed by the Minister of Public Health. Accreditation is granted by the National Institute for Insurance Against Disease and Invalidity (INAMI/RIZIV) if the doctor meets additional requirements including participation in CME (20 credit points a year). This accreditation is not obligatory but enables GP's to charge higher reimbursable fees to patients. To be appropriate for accreditation a CME course has to be recognized by a Licensing Committee. These courses will further on be called 'formal CME'. To be effective in optimizing the quality of palliative care provided by GP's, the CME courses should reach as much GP's as possible and be of high quality. Reviews indicate that the format and educational techniques used in CME sessions partially account for the effects on professional practice and health care outcomes [13–15]. Furthermore literature provides strategies to evaluate educational interventions by measuring four different criteria: (a) satisfaction of the participant i.c. doctor, (b) increased knowledge of the doctor, (c) improvement of the professional behavior of the doctor and (d) effects on the health status of the patient [16,17]. The importance of these measurements and their use in evaluating CME have been described. Nevertheless in Flanders it is not known whether these courses are evaluated and if so, what the results are. Also the level of attendance of these palliative care CME courses is not known. Without this knowledge the necessary assessment of the effectiveness of CME on palliative care is not possible. If we want to optimize the offer of CME (e.g. according to the international curriculum suggestions of the European Association for Palliative Care) we must know the current offer. Furthermore previous research revealed preferences and barriers of GP's for attending CME sessions. It is not known if and how providers of CME take these preferences and barriers into account when organizing CME.

Therefore we planned a descriptive study to give an overview of the formal CME in palliative care for GP's in Flanders.

Aim of the study

The following questions are addressed:

- Who provides the CME?
- What is the content, the format and what are the educational techniques used during the sessions?
- How many GP's take part?
- Are the activities evaluated and if so, by which criteria?
- What considerations (towards attendance of GP's) do providers of CME have when organizing CME sessions?

## 2. Methods

A survey was held among providers of formal CME for GP's using a questionnaire developed based on literature about content and effectiveness of continuing medical education. The selected providers are organizations that have the official (legal) task to provide CME to GP's. A survey of the official national database of all CME activities of the same year shows that the selected providers cover the landscape of CME in palliative care [18].

### 2.1. Sample and procedure

234 providers of formal CME for GP's were included in the study: all GP organizations ($n = 91$), palliative care organizations ($n = 18$), hospitals ($n = 121$) and universities ($n = 4$) of Flanders. All members of the target sample received an email announcing the questionnaire, addressed to the chairman, secretary, superintendent, head physician, principal or training manager of each organization. Two weeks later they received the questionnaire by email. Non-responders received a reminder one month later by regular post [19].

### 2.2. Questionnaire

The questionnaire consisted of questions based on literature into palliative care curriculum content [20] and effectiveness of continuing medical education [16,17,21]. Questions were based on the CME initiative of 2007 and instructions for use were included.

An introductory question asked about the total number of courses for GP's and the number of courses in palliative care for GP's provided by the organization in 2007.

The questionnaire itself asked for following items about every course: subject (categorized according to the undergraduate curriculum suggestions of the European Association for Palliative Care (EAPC)) [20], duration (h), profession/discipline of lecturer, media methods [21], didactical techniques [21], methods and level of evaluation [16,17], nature (disciplines) and number of target population, number of attending GP's.

A final question asked: 'what are the three most important items you take into account when organizing CME in palliative care for GP's?'.

The questionnaire was piloted among a panel of experts (working both in palliative care and in education) who commented on content, comprehensibility of the questions, choice of words and layout [22].

### 2.3. Data analysis

Descriptive statistics (SPSS 17.0) were used to analyse the answers on the questions. Known barriers and preferences for attending CME were used as categories for content analysis of the answers to the final question [23–25]. New categories were created when answers did not fit one of these (concerning specific palliative care items).

## 3. Results

### 3.1. Preliminary results

The overall response was 43% (102 out of 234). All responders answered the questions concerning the course-items and 51 of them (50%) answered to the final question concerning the preferences of GP's. All palliative care organizations ($n = 18$) responded to the questionnaire while universities ($n = 4$), hospitals ($n = 121$) and GP organizations ($n = 91$) gave much less response (2/4 = 50%; 48/121 = 39% and 34/91 = 37% respectively). As can be seen in Table 1, 78% of the palliative care organizations provided palliative care CME for GP's during 2007, while a smaller proportion of the responding universities, GP organizations and hospitals offered palliative care education to GP's (50%, 35% and

**Table 1**
Type and number of CME providers in Flanders that responded to the questionnaire and provided CME to GP's during 2007.

| Type of organization (total number) | Responders (percentage) | Provided CME during 2007 (percentage of responders) |
|---|---|---|
| Pall care organizations (18) | 18 (100%) | 14 (78%) |
| GP organizations (91) | 34 (37%) | 12 (35%) |
| Hospitals (121) | 48 (39%) | 8 (17%) |
| Universities (4) | 2 (50%) | 1 (50%) |
| Total (234) | 102 (43%) | 36 (35%) |

**Table 2**
Content of the palliative care CME activities for GP's during 2007 in Flanders.

| Theme | Percentage |
|---|---|
| Introduction in palliative care | 3.9 |
| Pain management | 11.8 |
| Symptom management | 26.5 |
| Psychosocial/spiritual | 12.7 |
| Ethics and law | 29.4 |
| Communication | 8.8 |
| Teamwork | 6.9 |
| Total | 100 |

17% respectively). In total, 36 (35%) of the responders offered CME in palliative care to GP's during 2007.

These 36 organizations together offered 106 palliative care CME activities to GP's (with a range from 1 to 11). As can be seen in Fig. 1, palliative care organizations offer 67% of the CME. The second major providers are GP organizations (19%) with hospitals being the third largest providers of CME at 13%. Universities provided 1% of the CME. In 19% of the activities, only GP's were invited, whereas in 20% of the activities GP's with other medical disciplines were invited. In 44% GP's with nurses were invited (Fig. 2).

### 3.2. Content, format and didactical techniques

There are two major themes: 'ethics and law' and 'symptom management' (29.4% and 26.5% of all activities respectively). The least offered themes were 'communication' and 'teamwork' (8.8% and 6.9% respectively). 'Introduction in palliative care', 'pain management' and 'psychosocial/spiritual problems' are themes with intermediate percentages (3.9%, 11.8% and 12.7% respectively) as can be seen in Table 2.

Data about format and educational techniques used during the sessions showed that 80% of all sessions were lectures with one or more speakers, often supported with power point presentations.

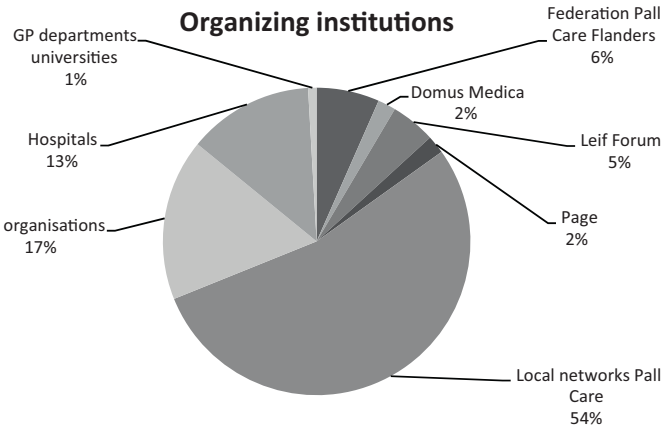


**Fig. 1.** type of organization providing CME in palliative care for GP in Flanders during 2007 Palliative care organizations (Federation Pall Care Flanders, Local networks Pall care, Leif Forum, Page) GP organizations (GP organizations, Domus Medica).

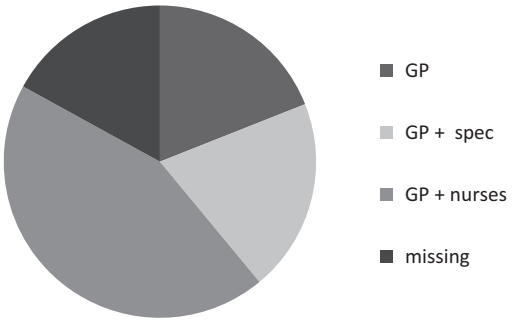


**Fig. 2.** distribution of CME activities for GP's according to disciplines in target population.

### 3.3. Number of participants in relation to target group

The number of attending GP's was low in comparison to the target population, seldom exceeding 15% (median 6.6; range 83.3; SD 22.7). The percentage of the target population that attended the courses was inversely correlated with the size of the target population (smaller target population – higher percentage) and with the number of disciplines invited (less disciplines – higher percentage). Topic (content) of the CME had no influence on the number of attending GP's.

### 3.4. Evaluation

The majority of the educational activities (73%) were not evaluated. The activities that were evaluated used a satisfaction questionnaire (70%) or a knowledge test (30%).

### 3.5. Answers to the final question (attention to preferences and barriers)

Providers of CME enumerate a range of items they take into account when organizing CME in palliative care for GP's. These items can be considered attempts to meet the preferences for GP's to attend CME in palliative care. The items were clustered around preferences and barriers as mentioned in literature: time, content, learning needs [23]. Location, contextual factors, speakers and ways of learning ('format') were added as new factors. The number of respondents that mentioned a theme is added between brackets.

- Time (18/51): Courses are scheduled in the evening or on Saturday to minimize the impact on daily practice.
- Location (5/51): Efforts are made to invite expert speakers to local organizations so that GP's do not have to drive large distances after hours.
- Contextual factors (10/51): CME providers consult local GP circles before developing their programs to prevent conflicts between agendas. When two different CME sessions are scheduled on the same day, often the CME in palliative care is not attended.
- Topic (18/51): Speakers are encouraged to restrict the share of theoretical knowledge.
- To focus on topics for direct application in clinical practice (25/51).
- Speaker (15/51): must be an expert in the topic and a qualified speaker.

**Table 3**
The efforts CME providers make to meet the perceived preferences of GP's for CME attendance.

| 'What are the most important items you take into account when organizing CME in palliative care for GP's?' (number of responders that mention the item) | Examples of ways to meet the preferences |
|---|---|
| Time (18/51) | Timing: evening or Saturday/short programs |
| Location (5/51) | Decentralization (local organization) |
| Contextual factors (10/51) | Making agreements with local GP circle for program development/credit points/looking for known speakers/drinks and meal after session |
| Topic (18/51) Ready for use in clinical practice (25/51) | Practical information for direct use/case reports/new developments/all topics: somatic, spiritual, policy/local initiatives/on demand of GP's/to the point/scientific |
| Educational needs (5/51) | Unclear if multidisciplinary training has added value/looking at daily practice/session on evel of GP knowledge |
| Format (5/51) | Offering support and coordination to GP/explaining collaboration with palliative home care teams |

- Educational needs (5/51): The educational needs of GP's are considered important but are not objectively being assessed and can therefore not be addressed. Providers of CME are not convinced of the added value of offering multidisciplinary education.
- Format (5/51): Interactive sessions are considered more efficient. Palliative care organizations state that collaboration of GP's with palliative home care teams is an alternative way of supporting GP's in their daily practice besides offering palliative care courses in the CME programs which are already overloaded.

An overview of these items can be seen in Table 3.

## 4. Discussion and conclusion

### 4.1. Discussion

This is the first review describing continuing medical education about palliative care for general practitioners in Flanders focusing on the way it is organized, provided, attended and evaluated. The results show a heterogeneous landscape of CME provided by different organizations with large gaps in the content and inefficient use of didactical techniques. The impact of these poorly attended courses on clinical practice cannot be described because the evaluation is not undertaken by CME providers.

In lots of countries providing postgraduate education is not the exclusive task of one organization [1]. This is also the case for Belgium where multiple organizations can take initiatives to provide palliative care education without any central deliberation or co-ordination. A survey of the complete database of CME in Belgium of the same year shows that only 5.18% (755/14570) of activities concerned palliative care and about half of these activities targeted GP's [18]. This could reflect the small number of palliative patients GP's take care for but it requires good planning to cover the field of palliative care in a limited offer of courses. Most of the CME on palliative care is provided by palliative care organizations and not by GP organizations, or by universities. This is in strong contrast with most of the general CME activities for GP's which are offered by local GP organizations according to their official task. Local palliative care organizations often have GP's in their board and have strong connections with local GP organizations. It could be assumed that mutual agreements exist for the CME on palliative care to be delivered by palliative care organizations. Concerning the universities they do not have a strong established role in CME in Flanders. Moreover, Belgium as several other countries, has no mandatory undergraduate palliative care curriculum for medical students [1]. This lack of academic 'palliative care tradition' could account for the absence of universities in the CME landscape on palliative care. However, recently universities took a joint initiative to prepare a postgraduate curriculum in palliative care as suggested by the EAPC [12].

This means that most of the CME on palliative care for GP's is delivered by palliative care organizations. They share the same educational task towards GP's according to curriculum content and endpoints. Since these palliative care organizations are joined in one umbrella organization, central co-ordination of the offer should be possible but is still lacking today. This might be one of the reasons why lectures on some topics are presented by almost every provider of CME, while other topics are never presented at all. One could acknowledge that some topics are more important or attractive than others and are therefore offered by multiple organizations. Nevertheless this causes an unnecessary overlap which exhausts means in an inefficient way. Central deliberation between all concerned organizations could overcome this shortcoming.

Some topics are thus presented by every provider (e.g. pain and symptom control) whereas other topics are generally lacking in the offer of CME on palliative care. This study shows that almost 40% of the courses deal with 'symptom management' or 'pain management'. This seems logical since good palliative care depends on good symptom control and GP's mention this as one of their most important educational needs [8,26]. On the other hand the offer lacks some topics, such as teamwork and communication, which are fundamental skills in palliative care and which are also perceived by GP's as learning needs [8,26]. Whether these topics are covered in general CME cannot be concluded from this study. Training in communication and teamwork may require different skills from trainers than the skills that are required to give a lecture on pain and symptom control. This could be a barrier for some organizations or speakers to address these topics. Assessing the palliative care learning needs of GP's and matching the CME offer to these needs might render the courses more efficient though the topic of the CME on palliative care in this survey does not seem to influence the number of attendees.

Data about format and didactical techniques used during the sessions show that about 80% of the sessions use lectures as a didactical technique though literature shows that lectures alone do not influence professional behavior or the quality of patient care [13,21]. Lectures belong to the longstanding tradition of general practitioner postgraduate education and traditions are difficult to change. Since the format of CME courses partially accounts for the efficiency of the courses and therefore could have an impact on the quality of care provided by GP's, providers of CME should make efforts to adopt the appropriate format. Interactive courses have shown to be more efficient than lectures and should therefore be preferred keeping in mind that this may involve additional efforts and costs [13]. The last decade has witnessed a change of focus from classical postgraduate education (with knowledge transfer as a goal) to competency focused education (continuing professional development) [27]. Self directed learning (based on personal learning plans according to personal learning needs) has been proven to be efficient and should be tried out in palliative care education for GP's [28,29].

The number of GP's that attended the activities was low in comparison to the target population, seldom exceeding 15%. A smaller target population results in a higher percentage of attendees indicating that GP's prefer local courses instead of larger centralized courses. The attendance of GP's to the courses was even lower when more than one discipline was invited. This should yet be stimulated since multidisciplinary education can be of added value in changing practice [30,31]. GP's acknowledge their learning needs on palliative care. On the other hand GP's have to keep up their knowledge and skills on a wide range of topics considering the nature of their job. Preference of CME courses to attend may be given to other more frequently encountered medical topics than to palliative care.

Mostly the sessions were not evaluated. Formal approval of medical educational courses in Belgium is based on administrative requirements and not on quality criteria. Yet formal approval of educational courses does not always guarantee quality [32]. Therefore evaluation of the courses is necessary. Methods to measure the effectiveness of CME have been studied [17] and suggestions have been made to evaluate them by four different criteria: (a) satisfaction of the participant, (b) increased knowledge of the participant, (c) improvement of the professional behavior of the doctor and (d) effects on the health status of the patient [16]. Providers of CME should be encouraged to execute evaluations based on these criteria.

The answers to the final question show a range of barriers and preferences of GP's for CME attendance as perceived by CME providers. Since most of these providers are GP's or have GP's in their boards their insight into the barriers and preferences should be valuable. This assumption is supported by the fact that their insight resembles the results of previous studies on the same topic [23,24]. Efforts are being made to overcome the barriers. Preferences on timing, location and logistics (e.g. catering when evening session) can relatively easily be met by deliberating agendas together with GP representatives. Concerns about content can be resolved by questioning the target population of GP's. Whether this way of deciding on the content of the sessions is responsible for the content gaps in the offer could not be concluded from this study. Focus on practice based topics could render the content more applicable. Palliative care will always remain a smaller proportion of the daily work of GP's and therefore palliative care courses risk to remain less attractive for GP's than courses on, e.g. diabetes or cardiovascular diseases. Clarifying the palliative care concept as a total care approach meeting the needs of a lot more patients than just the terminally ill cancer patients might help to overcome this barrier.

Some remarks can be made about this study. First there is the low response rate of 43%. A survey of the official national database of CME activities of the same year shows that in Flanders 166 palliative care educational sessions were organized for GP's. Our review reports of 106 educational sessions representing almost 64% (106/166) of all palliative care courses. This makes the analysis of their attributes sufficiently representative for the way post-graduate palliative care education is organized. Secondly we used the undergraduate curriculum suggestions of the EAPC to categorize the content of the sessions instead of the postgraduate curriculum suggestions which were not yet developed at the time of our study. Recently the postgraduate curriculum suggestions have been published and comparison of both curricula shows that they can be categorized in the same way so this limitation had no substantial effect on the results of our study. Thirdly we did not look into other ways of acquiring palliative care expertise like working together with palliative home care teams or consulting palliative care specialists. This may be efficient ways for individual GP's to learn (completing or substituting formal CME) and should be evaluated separately.

### 4.2. Conclusion

This study investigated the landscape of formal continuing medical education in palliative care for general practitioners in Flanders. Data showed that the content was incomplete, the didactical technique used during the sessions was inappropriate, attendance was low and the quality of the sessions was not evaluated. Providers of CME were aware of the barriers and preferences of GP's to attend the sessions but were not able to meet all of them. Reflections are made to improve the offer.

### 4.3. Practice implications

The 'Federation Palliative Care Flanders' is an umbrella organization for all palliative care organizations in Flanders and should take a leading role in coordinating CME on palliative care. Based on existing guidelines (e.g. postgraduate curriculum suggestions of the EAPC) a comprehensive offer of CME sessions should be installed in a coordination between all providers of CME and communicated to all GP's. This could render the use of means (logistics and speakers) more efficient. The overall use of lectures as educational technique should make place for interactive small group discussions.

Since the current offer of CME seems inefficient further research could be performed towards other ways of acquiring palliative care competences such as evaluating the learning effect of GP's working together with specialized palliative home care teams.

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